



# Linking the menopause rating scale to the International classification of functioning, disability and health – A first step towards the implementation of the EMAS menopause health care model



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## ABSTRACT

**Objectives:** To link the Menopause Rating Scale (MRS-II) to the International Classification of Functioning, Disability and Health (ICF) and present a clinical application of an ICF-based tool.

**Study design:** The MRS-II was linked to the corresponding ICF category. The linked items were used to generate an ICF Categorical Profile. To broadly examine its feasibility in clinical practice, qualitative interviews with three patients were performed.

**Main outcome measures:** Corresponding items of the MRS-II in the ICF. Perception of the ICF Categorical Profile from patients' perspective.

**Results:** A total of 44 concepts from the MRS-II were identified that could be linked to 24 different ICF categories, which all belonged to the component Body Functions. From patients' perspective, filling in the ICF Categorical Profile helped to structure their goals but did not improve the overview of symptoms.

**Conclusions:** The ICF Categorical Profile could be a valuable tool in menopause healthcare; however, it is necessary to adapt the ICF for this specific use. An ICF Core Set needs to be developed in order to accomplish the goal of the European Menopause and Andropause Society and implement its Healthy Menopause Health Care Model in daily practice.

## 1. Introduction

Estrogen deficiency due to menopause affects a woman on all levels, from subcellular structures, organs, regulatory systems to bio-mental-psycho-social functioning [1]. Accordingly, various (non)specific symptoms may occur, called climacteric syndrome. Despite its multidimensional phenotype it has been classified only unidimensionally so far using the ICD-10 (N95) [2]. Recently, the European Menopause and Andropause Society (EMAS) proposed a new Healthy Menopause Health Care Model which aims to set up a personalized care plan for short-, mid- and long-term goals in the context of physical, psychological and social functioning [3]. This holistic approach is based on the conceptual framework of the Healthy Menopause (HM) [4] and the International Classification of Functioning, Disability and Health (ICF) endorsed by the WHO [5]. The ICF's goal is to "establish a common language for describing health and health-related states in order to improve communication between different users". A core part of to the

ICF are its five components Body Functions, Body Structures, Activity and Participation, Environmental Factors and Personal Factors which are used to holistically describe the patient's functioning.

We propose that the climacteric syndrome (ICD N95) should be mapped and differentiated according to the ICF to describe the patient's functioning and needs in more detail and to create a common language facilitating the interdisciplinary communication and clinical documentation. In a first step we had analyzed the diffusion of the ICF across different health conditions and regions in Switzerland to gain a first impression on its implementation and to draw practical conclusions for its application to the concept of healthy menopause and ageing [6]. We found an active use of the ICF, especially in the field of rehabilitation. Here, it had been shown that the ICF was already successfully used to map in great detail the patient's functioning and facilitate interdisciplinary collaboration [7]. However, the ICF has not yet been applied in menopause medicine. This provides an opportunity to further investigate how the ICF could be adapted for its application in

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menopause medicine. To follow EMAS guidelines, it is necessary to adapt the existing ICF-based instruments for assessment of patients with menopausal symptoms. Thus, the aim of this study was to link the Menopause Rating Scale (MRS-II) [8] to the ICF and to present a clinical application of an ICF-based tool, the Categorical Profile [9]. To examine the feasibility of this tool in clinical practice, we furthermore conducted qualitative assessments with three patients to gain first impressions on how the ICF-based Categorical Profile could be integrated in daily routine and to identify possible improvements and shortcomings.

## 2. Material and methods

### 2.1. Selection of assessments

We chose the validated MRS-II as it is frequently used in daily practice as well as in research [10]. It is a self-administrative rating scale made up of 11 items. The severity of each item can be assessed on 5-point scale (0 = none, 4 = very severe) resulting in a maximum score of 44. It can be divided into three subdomains, psychological subdomain (four symptoms), somato-vegetative subdomain (four symptoms) and urogenital subdomain (three symptoms). The ICF Categorical Profile was chosen as an ICF-based instrument as it allows the realization of the EMAS idea to set up a personalized care plan for short-, mid- and long-term goals. It visualizes the extent of limitation for chosen ICF categories at the time of assessment. The physician and patient then together elaborate which goals they want to achieve. Generally, the ICF Categorical Profile is based on a corresponding ICF Core Set. However, as no ICF Core Set for the climacteric syndrome exists, it was decided to link the MRS-II as a first step.

### 2.2. Linking the MRS-II to the ICF

We used the redefined linking rules to link the MRS-II to the ICF [11]. According to these linking rules, the main concept contained in each item of the assessment was identified and linked to the most precise ICF category. If the item contained more than one meaningful concept the additional concepts were identified and separately linked to the most precise ICF category.

As demanded by the redefined linking rules, we documented the perspective taken on and the categorization of the response options (Supplement 1, Linking table). Two researchers (MZ, DP) who were trained in the linking methodology conducted the linking independently. Differences in the linking were discussed until consensus was reached. If no consensus between the two researchers could be reached, a third researcher (PS) was consulted to make a final decision on the most precise linking. The reasoning was documented in a research diary as recommended by Cieza et al. which also includes the reasoning for the exclusion of concepts and ICF codes (Supplement 2, Linker's Guide).

### 2.3. Adaptation of the MRS-II for the application within an ICF categorical profile

After the linking had been completed, an ICF Categorical Profile was created from the ICF categories that resulted from the linking process. As the MRS-II uses the same qualifiers as the ICF Categorical Profile (0 = no problem to 4 = complete problem), no adaptation was needed for the use of the qualifiers. Based on the Healthy Menopause Health Care Model, we decided to name one short-, one mid-term and one long-term goal that patient and physician evaluated together and that should guide the therapeutic decisions.

### 2.4. Application of the ICF categorical profile

To assess the practical applicability of the newly developed ICF Categorical Profile, we conducted qualitative assessments with three

patients. Participation in the study was voluntary and anonymous. As these were single case studies, approval by the cantonal ethic committee was not necessary. A jurisdictional inquiry at the ethical committee confirmed this (KEK Req-2017-00863) (<https://www.kofam.ch/en/applications-and-procedure/projects-that-do-not-require-authorisation/>). The patients consented with publishing the interview data. All three patients were treated in the menopause clinic at the Department of Obstetrics and Gynecology Inselspital Bern, and were seen by the same health provider (PS). They were randomly chosen such that Patient 1 came for a first consultation, Patient 2 also came for a first consultation and a three-month follow-up consultation where the interview took place and Patient 3 who came for a routine follow-up consultation. The patients filled in the MRS-II prior to the consultation as it is standard at this clinic. During the consultation, the physician (PS) transferred the data into the ICF Categorical Profile and patient and physician discussed the goals to be achieved during therapy according to the ICF Categorical Profile. Following the appointment, the patients were asked questions in a semi-structured interview (MZ). The questions covered the possible improvements by the clinical use of an ICF Categorical Profile. During the interview, the examiner took handwritten notes of the most important inputs. The conversations were held in Swiss German and audio-recorded for a later transcription. The answers given were copied into a spreadsheet where the relevant interview citations were reduced to the core statements and translated to English (Supplement C).

## 3. Results

### 3.1. Linking

We identified 44 concepts in the MRS-II (including examples given) which could be linked to 24 different ICF categories which all belonged to the component Body Functions. Of these, 15 items were categorized as second level, eight as third level and one as fourth level. No concept was linked to the components Body Structures, Activity and Participation, Environmental Factors and Personal Factors, which are not covered by the MRS-II. Table 1 presents the detailed linking. Table 2 presents an overview of the linking reported at ICF chapter level. The numbers in the table represent the frequencies with which the ICF categories were addressed in the MRS-II. It shows that within the chapter Body Function, the MRS-II focuses on the chapter b1 Mental Functions and b6 Genitourinary and Reproductive Functions.

### 3.2. Categorical profile

An ICF Categorical Profile was set up with the linked items from the MRS-II. For a better overview, the original items of the MRS-II were also included. It was decided to mention b152 Emotional Function according to the MRS-II three times with the specification in brackets as otherwise we were concerned to lose substantial information. According to the Healthy Menopause Health Care Model patient's goals were adjusted to short- (three months), middle- (< 12 months) and long-term (> 12 months) goals. Each ICF item could be linked to the corresponding goal and according to these goals patient and physician set a goal value for each item. An example of an ICF Categorical Profile is shown Table 3.

### 3.3. Interview analysis

Patient 1 was a 49-year old woman presenting for consultation at the menopause clinic for the first time. Her MRS-II total score was seven (psychological subdomain: one point, somato-vegetative subdomain: three points, urogenital subdomain: three points). Filling in the ICF Categorical Profile did not help her defining the problems as they had been clear to her before. However, it helped her to understand that her symptoms were connected. Until then she had not thought about the

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